I negate,

To negate means **deny the truth** which implies **a**) presume neg since the aff has the proactive burden, **b**) permissibility negates, if I prove the resolution is not obligatory, you negate. Prefer substantive presumption since if I win we ought to see the resolution as false then the debate isn’t a tie – I did the better debating by showing we should negate. Indicting assumptions triggers presumption since I can’t posit something about a statement that is incoherent.

And, proving that autonomous medical choices are incoherent negates: **a**) the resolution asks whether adolescents ought to have the right to make autonomous medical choices, if such choices are incoherent then it is impossible for adolescents to have such a right, thus my burden is most textual with the resolution. Textually is key because it is the sole basis for pre pound prep. Also arguments against the burden are counter interpretations because the aff has the burden to be topical **b**) we always accord more moral worth to things which are possible than things which inconceivable. It would be self-defeating to instruct moral theories to find a correct action that is impossible to make. **c**) Autonomous is defined as “not subject to the control from outside.[[1]](#footnote-1)” Prefer this definition because the context of the resolution is to be able to make medical choices independent from outside control. Context controls the internal link because we can only determine definitions within their defined contexts. Also key to education because it is defined as it in the topic literature. Ability to make autonomous medical choice’s requires that agency exists, thus any claim that agency doesn’t exist precedes the ability to make a decision in the first place. Also this outweighs because it shows that the right as a whole is incoherent any aff claim against such an argument would be non-unique.

**I contend** that autonomous medical choices are an incoherent.

**First**, Autonomous medical choices are impossible; we have innate limitations and biases towards what information we can manage. **Butkus:** “Neuroethics Free Will and Autonomous Medical Decision- Making” Dr. Matthew A. Butkus earned his undergraduate degrees from Georgetown University (German and Philosophy) and the University of Pittsburgh (Psychology). He earned his graduate degrees from Duquesne University (MA in Philosophy and PhD in Health Care Ethics). He is currently an Associate Professor in the Department of Social Sciences at McNeese State University. His prior academic and clinical appointments include Chatham University, Mercy Hospital–North Shore Campus, the CRISMA Research Group in the Department of Critical Care Medicine at the University of Pittsburgh Medical Center (Clinical Research, Investigation, and Systems Modeling of Acute Illness), and St. Francis Health System. PE

**In a clinical setting**, this is a description of our idealized patient and our ideal of informed consent—authentic **choices predicated on an understanding of** the procedures and **risks** involved **and** knowledge of the reasonably predictable **outcomes.** There is a problem, however—this standard is **[are] impossible**. **We have innate limitations on how much information we can manage** in constructing these scenarios; as a consequence, we tend only to alter simple elements or factors, which may not conform to reality or may be counterintuitive (Tversky & Kahneman 1982). Further, once we construct a particular scenario, **we tend to find it difficult to imagine other possibilities—we become** tied or ‘**anchored’** **to one given** possible explanation or course of **action**, **which limits our ability to generate further scenarios** or to see other potential outcomes. Tversky and Kahneman further note that **in judging probabilities** and unknowns, our decisions are only adequate if the judgment is in accord with the entire collection of beliefs held by the thinking agent. **This poses a problem in assessing rationality:** **there is no** simple **way to check whether any** particular **set of** probability **judgments are compatible with the individual’s collective whole**. **Instead, the individual simply strives for conscious and unconscious compatibility** with his knowledge, assessments of probability, **and his own** heuristicsand **biases**. In other terms, the individual strives to make his decision as authentic as possible. Further modifying our knowledge pool complicates our decisional framework—we respond differently when we begin to add information into our cognitive schema. Our mind can have difficulty filtering useful information from worthless information—studies demonstrate that “people respond differently when given no evidence and when given worthless evidence. When no specific evidence is given, prior probabilities are properly utilized; when worthless evidence is given, prior probabilities are ignored” (Tversky & Kahneman 1982, 5). When information is present, we assign it decisional weight and importance, but may potentially give it undue weight, leading us to become either overly reliant upon that particular piece of information (anchoring), or overly confident in our assessment of its worth, a failure rampant across lay and professional decision makers. **Human cognition does not follow an overtly rational process like** pure **information processing and utility maximization; our cognition is characterized by** values, **emotions**, prior knowledge, raw intelligence, and many other factors that do not fit nicely into this idealized model. Accounts or theories of autonomy must reflect this messiness to be sound—**if our philosophy is not influenced** and tempered **by what we learn from neuroscience** and cognitive psychology**, it is an exercise not in truth but in fiction** (Lakoff ) 1999). Special interest in concepts like backstage cognition and heuristics and biases can be traced back decades (Ashcraft 1994; Gigerenzer 1996; Gigerenzer, Czerlinski, and Martignon 2002; Gilovich & Griffin 2002; Kahneman 2011; Tversky & Kahneman, 1982), but medical ethics has not broadly integrated these findings. Models of medical autonomy from that period evidence a classical understanding of rationality and reason, and three principle models serve as examples.

#### Second, all acts are merely events in time, not caused by agents. Parfit: Derek Parfit, On What Matters, Vol. 1. 2011.

When someone acts for some reason, however, we can ask why this person acted for this reason. In some cases, the answer is given by some further reason. My reason for telling some lie, for example, may have been to conceal my identity, and my reason for concealing my identity may have been to avoid being accused of some crime. But we shall soon reach the beginning of any such chain of motivating reasons. My ultimate reason for telling my lie may have been to avoid being punished for my crime. When we reach someone’s ultimate reason for acting in some way, we can ask why this person acted for this reason, rather than acting in some other way for some other reason. If I had a self-interested reason to try to avoid being punished, and a moral reason not to tell this lie, why did one of these reasons weigh more heavily with me, so that I chose to act as I did? This event did not occur for some further motivating reason. So the suggested third alternative here disappears. This event was either fully caused or partly random. And there is always such an event at the start of any chain of motivating reasons. Since our decisions to act as we do all involve such events, there is no coherent third alternative.¶ To avoid this argument, some people claim that acts can be caused by agents in a way that does not involve any event. Such believers in agent-causation partly accept Kant’s view that, if our acts were merely events in time, we could not have any kind of freedom that could make it true that we can deserve to suffer because of what we did. But these¶ writers believe that, as agents, we are fully part of the spatio-temporal world, so they cannot intelligibly claim that the causing of acts by agents are not events.

#### Third, the universe already has a future that determines the present. Merali: Zeeya Merali, “Back From the Future”, Discover, April 2010 issue

In 1964 Aharonov and his colleagues Peter Bergmann and Joel Lebowitz, all then at Yeshiva University in New York, proposed a new framework called [time-symmetric quantum mechanics](http://physics.princeton.edu/~mcdonald/examples/QM/aharonov_pr_134_b1410_64.pdf). It could produce all the same treats as the standard form of quantum mechanics that everyone knew and loved, with the added benefit of explaining how information from the future could fill in the indeterministic gaps in the present. But while many of Aharonov’s colleagues conceded that the idea was built on elegant mathematics, its philosophical implications were hard to swallow. “Each time I came up with a new idea about time, people thought that something must be wrong,” he says. Perhaps because of the cognitive dissonance the idea engendered, time-symmetric quantum mechanics did not catch on. “For a long time, it was nothing more than a curiosity for a few philosophers to discuss,” says Sandu Popescu at the University of Bristol, in England, who works on the time-symmetric approach with Aharonov. Clearly Aharonov needed concrete experiments to demonstrate[s] that actions carried out in the future could have repercussions in the here and now. Through the 1980s and 1990s, Tollaksen teamed up with Aharonov to design such upside-down experiments, in which outcome was determined by events occurring after the experiment was done. Generally the protocol included three steps: a “preselection” measurement carried out on a group of particles; an intermediate measurement; and a final, “postselection” step in which researchers picked out a subset of those particles on which to perform a third, related measurement. To find evidence of backward causality—information flowing from the future to the past—the experiment would have to demonstrate that the effects measured at the intermediate step were linked to actions carried out on the subset of particles at a later time. Tollaksen and Aharonov proposed analyzing changes in a quantum property called spin, roughly analogous to the spin of a ball but with some important differences. In the quantum world, a particle can spin only two ways, up or down, with each direction assigned a fixed value (for instance, 1 or –1). First the physicists would measure spin in a set of particles at 2 p.m. and again at 2:30 p.m. Then on another day they would repeat the two tests, but also measure a subset of the particles a third time, at 3 p.m. If the predictions of backward causality were correct, then for this last subset, the spin measurement conducted at 2:30 p.m. (the intermediate time) would be dramatically amplified. In other words, the spin measurements carried out at 2 p.m. and those carried out at 3 p.m. together would appear to cause an unexpected increase in the intensity of spins measured in between, at 2:30 p.m. The predictions seemed absurd, as ridiculous as claiming that you could measure the position of a dolphin off the Atlantic coast at 2 p.m. and again at 3 p.m., but that if you checked on its position at 2:30 p.m., you would find it in the middle of the Mediterranean. And the amplification would not be restricted to spin; other quantum properties would be dramatically increased to bizarrely high levels too. The idea was that ripples of the measurements carried out in the future could beat back to the present and combine with effects from the past, like waves combining and peaking below a boat, setting it rocking on the rough sea. The smaller the subsample chosen for the last measurement, the more dramatic the effects at intermediate times should be, according to Aharonov’s math. It would be hard to account for such huge amplifications in conventional physics. For years this prediction was more philosophical than physical because it did not seem possible to perform the suggested experiments. All the team’s proposed tests hinged on being able to make measurements of the quantum system at some intermediate time; but the physics books said that doing so would destroy the quantum properties of the system before the final, postselection step could be carried out. Any attempt to measure the system would collapse its delicate quantum state, just as chasing dolphins in a boat would affect their behavior. Use this kind of invasive, or strong, measurement to check on your system at an intermediate time, and you might as well take a hammer to your apparatus. By the late 1980s, Aharonov had seen a way out: He could study the system using so-called weak measurements. (Weak measurements involve the same equipment and techniques as traditional ones, but the “knob” controlling the power of the observer’s apparatus is turned way down so as not to disturb the quantum properties in play.) In quantum physics, the weaker the measurement, the less precise it can be. Perform just one weak measurement on one particle and your results are next to useless. You may think that you have seen the required amplification, but you could just as easily dismiss it as noise or an error in your apparatus. The way to get credible results, Tollaksen realized, was with persistence, not intensity. **By 2002** **physicists** attuned to the potential of weak measurements **were repeating their experiments thousands of times, hoping to build up a bank of data persuasively showing evidence of backward causality** through the amplification effect. **Just last year**, physicist John Howell and his team from the **U**niversity of **Rochester** [reported success](http://physics.aps.org/viewpoint-for/10.1103/PhysRevLett.102.173601). In the Rochester setup, laser light was measured and then shunted through a beam splitter. Part of the beam passed right through the mechanism, and part bounced off a mirror that moved ever so slightly, due to a motor to which it was attached. The team used weak measurements to detect the deflection of the reflected laser light and thus to determine how much the motorized mirror had moved. That is the straightforward part. Searching for backward causality required looking at the impact of the final measurement and adding the time twist. In the Rochester experiment, after the laser beams left the mirrors, they passed through one of two gates, where they could be measured again—or not. If the experimenters chose not to carry out that final measurement, then the deflected angles measured in the intermediate phase were boringly tiny. But if they performed the final, postselection step, the results were dramatically different. When the physicists chose to record the laser light emerging from one of the gates, then the light traversing that route, alone, ended up with deflection angles amplified by a factor of more than 100 in the intermediate measurement step. Somehow **the later decision appeared to affect the outcome of the weak**, intermediate **measurements, even though they were made at an earlier time. This amazing result confirmed a similar finding** [reported a year earlier](http://www.sciencemag.org/cgi/content/abstract/319/5864/787) by physicists Onur Hosten and Paul Kwiat at the University of Illinois at Urbana-Champaign. They had achieved an even larger laser amplification, by a factor of 10,000, when using weak measurements to detect a shift in a beam of polarized light moving between air and glass. For Aharonov, who has been pushing the idea of backward causality for four decades, the experimental vindication might seem like a time to pop champagne corks, but that is not his style. “I wasn’t surprised; it was what I expected,” he says Paul Davies, a cosmologist at Arizona State University in Tempe, admires the fact that Aharonov’s team has always striven to verify its claims experimentally. “This isn’t airy-fairy philosophy—these are real experiments,” he says. Davies has now joined forces with the group to investigate the framework’s implications for the origin of the cosmos (See “Does the Universe Have a Destiny?” below).Vlatko Vedral, a quantum physicist at the University of Oxford, agrees that the experiments confirm the existence and power of weak measurements. But while the mathematics of the team’s framework offers a valid explanation for the experimental results, Vedral believes these results alone will not be enough to persuade most physicists to buy into the full time-twisting logic behind it. For Tollaksen, though, the results are awe-inspiring and a bit scary. “It is upsetting philosophically,” he concedes. “All these experiments change the way that I relate to time, the way I experience myself.” The results have led him to wrestle with the idea that the future is set. If the universe has a destiny that is already written, do we really have a free choice in our actions? Or are all our choices predetermined to fit the universe’s script, giving us only the illusion of free will?

Therefore, free will doesn’t exist because the future already exists and determines what we do now instead of vice versa as choice implies.

**Fourth,** Neuroscience has demonstrated that our internal cognition is deterministic. **Butkus:** “Neuroethics Free Will and Autonomous Medical Decision- Making” Dr. Matthew A. Butkus earned his undergraduate degrees from Georgetown University (German and Philosophy) and the University of Pittsburgh (Psychology). He earned his graduate degrees from Duquesne University (MA in Philosophy and PhD in Health Care Ethics). He is currently an Associate Professor in the Department of Social Sciences at McNeese State University. His prior academic and clinical appointments include Chatham University, Mercy Hospital–North Shore Campus, the CRISMA Research Group in the Department of Critical Care Medicine at the University of Pittsburgh Medical Center (Clinical Research, Investigation, and Systems Modeling of Acute Illness), and St. Francis Health System. PE

**Psychology and neuroscience have demonstrated that consciousness**, our day-to- day perception, our sense of self and **identity**, judgment, emotions, **and intuitions are all predicated upon** a number of causal **cognitive elements that are outside our awareness**— **the bulk of our cognition is deterministic** and preconscious. **This** determinism **opens up avenues of undue influence into processes we normally assume to be under our control**— it should be clear that this assumption is mistaken at best, inhuman and pernicious at worst. **We should not abandon ourselves to blind determinism**, however—we possess the ability to reflect upon our motivations, and to engage in dialogic interaction with others, who may bring aspects of ourselves to the fore which would remain otherwise inaccessible. As a result, we can take back a measure of control, but only if we engage in honest dialectic and dialogue with others. **In the context of patient autonomy** and decision-making, the necessity of this dialogical process is especially evident—**patients are already physically compromised, potentially in ways that can exert conscious and unconscious influence over their decision-making processes**, above and beyond the normal potential sources of error found in heuristics and biases. Clinicians should be alert for such influences, recognizing that a medical illness can easily mask a deeper psychopathology. Affective disorders are very common, occur more in patients than in the general population, and tend to go unrecognized or dismissed as a normal reaction to their illness. The effect of these disorders, however, is quite pernicious. They fundamentally affect the efficacy of therapeutic interventions, morbidity and mortality, and rate of recovery—ignoring, dismissing, or failing to identify a comorbidity compromises the treatment of the obvious illness. By only treating the surface pathology, we potentially ignore the deeper wound. **Many contemporary models of autonomy suffer from similar shortcomings**—while ethics seeks to inform itself of philosophical, legal, theological, and medical constructs, it all too easily ignores the psychological, an unfortunate irony in light of the fundamental connection between cognitive and clinical psychology and ethical ideals of autonomous choice. Ethical theories that dismiss or fail to address psychological constructs are groundless; models derived from inhuman absolutes are so much fancy and fiction. What good is it to describe models of cognition that have little resemblance to how we actually think? The present autonomy model suggests that decision-making is a complex construct necessarily containing rational and emotional elements, intuitive judgments, and, as a result, potential sources of error. This seems to gel with day-to-day experience— many decisions are made by gut instinct and intuition, instead of a Cartesian rational process methodically and algorithmically exploring all possible influences, outcomes, and variables.

Thus, even if we have a basis of certain choices and actions doesn’t prove that humans get to make such choices. Thus the aff must show that why people make the decisions in in an indeterminate world.

**Finally,** Even if autonomous choices are possible they are highly influenced by stimuli and thus trigger involuntary behaviors. **Butkus:** “Neuroethics Free Will and Autonomous Medical Decision- Making” Dr. Matthew A. Butkus earned his undergraduate degrees from Georgetown University (German and Philosophy) and the University of Pittsburgh (Psychology). He earned his graduate degrees from Duquesne University (MA in Philosophy and PhD in Health Care Ethics). He is currently an Associate Professor in the Department of Social Sciences at McNeese State University. His prior academic and clinical appointments include Chatham University, Mercy Hospital–North Shore Campus, the CRISMA Research Group in the Department of Critical Care Medicine at the University of Pittsburgh Medical Center (Clinical Research, Investigation, and Systems Modeling of Acute Illness), and St. Francis Health System. PE

Preconscious processes develop as the result of conditioning—**we develop patterns of psychological responses to stimuli**. As is claimed by behaviorist thought, **we make associations between stimuli and psychological responses**, facilitating future responses along those same psychobehavioral lines. It becomes easier for stimuli to elicit behavioral, emotional, and motivational responses in us, producing automatic cognitive processing. Initially these responses require work, but **like other recurring responses, the amount of conscious effort they require consistently decreases to the point where they require no conscious processing at all** (Bargh 1997). **This** has serious ramifications—it **means** that if **we encounter a particular cognitive trigger, we can initiate goals, motivations, and resultant behaviors automatically.** **Absent volitional control, we may not necessarily be able to control the kinds of thoughts and actions** that result. **In a clinical setting,** for instance, **a particular diagnosis may be an emotional trigger for a variety of subsequent thought processes and associations**. The mere word ‘**cancer’ may elicit a slew of memories and experiences involuntarily** and instigate thought processes culminating in a comorbid depression, which may radically affect how our patient perceives his or her current health and prognosis. **When asked about treatment preferences,** and whether the patient desires a particular course of treatment, **we may have unknowingly set into action an automatic process that results in an outcome our patient might not otherwise desire.**

Underviews:

First, theory interps about acceptable NC standard or advocacy practices must be in the 1AC. Net benefit is strat skew- otherwise you get bidirectional theory. You can go for bidirectional interps which screws the neg every time since you always have a violation and an extra speech to defend it. Also more substantive debate since you can say what you want the debate to be and avoid unnecessary theory. Key to predictability since we prep the topic, not random theory issues.

1. http://dictionary.reference.com/browse/autonomous [↑](#footnote-ref-1)